

NEUROLOGIC RELIEF CENTER SURVEY

PURPOSE: To raise your awareness of any health problems you may be having and possible solutions.

Name _____ Age _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Email _____ Occupation _____



Check the boxes for any of the following symptoms you may have experienced in the past few months:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Fatigue, Tired | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Failed Surgeries |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Wrist/Hand Pain | <input type="checkbox"/> Ankle/Foot Pain |
| <input type="checkbox"/> Digestive Disturbance | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Ringing in the Ears |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Numbing/Tingling in Legs or Feet |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Numbing/Tingling in Arms or Hands |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other _____ |

Which of the above bothers you the most? _____

How long have you been bothered by this condition? _____

What is your current pain/symptom level on a scale 1-10 (10 being the worst)? _____

What have you tried to correct the problem? _____

Check the boxes of how this affects your life:

- | | |
|---|--|
| <input type="checkbox"/> Moody | <input type="checkbox"/> Lose Patience with Spouse or Children |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Restricted Household Duties |
| <input type="checkbox"/> Interrupt Sleep | <input type="checkbox"/> Decreased Productivity |
| <input type="checkbox"/> Restricted on Daily Activities | <input type="checkbox"/> Exhausted at the End of the Day |
| <input type="checkbox"/> Slower in Movement | <input type="checkbox"/> Interferes with Ability to Participate in Hobbies or Other Desired Activities |
| <input type="checkbox"/> Decision Making | <input type="checkbox"/> Hinders Ability to Exercise or Participate in Sports |
| <input type="checkbox"/> Poor Attitude | |
| <input type="checkbox"/> Unable to Work Long Hours | |

NRCT™ (Neurologic Relief Centers Technique) may be able to HELP YOU.
 In many cases people experience a relief of the majority of their symptoms at the time of testing that can last minutes, hours or even days.

Would you like to get relief? Yes No

If your answer is Yes, please check the item most appropriate for you.

- I would like to come to the office for a complimentary non-invasive Relief Test with the Doctor. This will allow me to find out if I can be helped by the Neurologic Relief Centers Technique without any obligation.
- I would like the Doctor to call me to discuss my health problems before making an appointment.

Are you a member of an HMO or Health Care Network? Yes No Name of HMO _____

Authorization

I hereby authorize Dr Alex Foote to perform the free test using the innovative NRCT™ (Neurologic Relief Centers Technique), a non-invasive orthopedic test. Our test usually relieves a percentage of your symptoms that may last minutes, hours, or even days. Although we have never had an issue with this test in the past, there is always a possibility for complications. I release Dr Alex Foote if any liability for any complications that might arise. I also agree to let Neurologic Relief Centers, LLC use any video or photographic material I may appear in, in any way they see fit to further research and awareness.

Sign
 Name: _____ Date: _____
 Print
 Name: _____

Internal Use Only	Level 1-10 (10 Worst)
Symptoms Before Test	
Symptoms After Test	
Other Misc. Notes	
	Seminar
	Date
	Coordinator